Testimony of Claudia Jensen, M.D.
for the House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Marijuana and Medicine:
The Need for a Science Based Approach

April 1, 2004

I am very grateful for the opportunity to submit my written testimony to the Members of the Subcommittee of the Committee on Government Reform. Thank-you. I am also thankful for the opportunity to have five minutes of oral presentation time. I apologize for the summarized nature of this report as I was invited to speak on March 16, 2004 and have had minimal time to prepare. I pray Members of the Subcommittee as well as the Committee on Government Reform will read the enclosed information with the intention of considering actual social reform.

I am a 49 year old mother of two teenage daughters, and a Physician educated at the University of Arkansas for both undergraduate and medical schools. I studied Pediatrics at the University of California at Irvine, completing my Internship and Residency training in 1981. I have a total of 23 years working as a Pediatrician, first as an HMO physician with Cigna HealthPlans, then in private practice in Ventura, CA.[1]

I currently work two days a week in a small community clinic servicing a poor patient population, three days a week in my own private office and I teach first year medical students one day a week at the University of Southern California Keck School of Medicine. I have always had a reputation for being a patient advocate since the very beginning of my training.

Congressman Souder has asked me to discuss my "practice" of recommending "marijuana" for use by "dozens of patients, including children with ADD.[2]" This "practice" is a direct consequence of California's passing of the Compassionate Use Act of 1996[3] (Health and Safety Code 11362.5, also known as Proposition 215) and my compliance with the law as determined by State of California[4] and the United States Supreme Court.[5] The people of the State of California, as well as a majority of Americans[6] believe marijuana should be available to patients who are ill or in pain. Contrary to popular opinion and scientific fact, it is the position of the Government of the

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[1] Jensen, Claudia, M.D., Curriculum Vitae, 2004.
[2] Invitation to speak to the Subcommittee on Criminal Justice, Drug Policy and Human Resources, March 16, 2004.
[3] Health and Safety Code 11362.5, entire text.
[4] State of California, Senate Bill 420.
[5] Conant v. McCaffrey, No. C97-00139 WHA, subsequent Ninth Circuit Court of Appeals Decision and Supreme Court refusal to hear the appeal.
[6] Stein, Joel, "The Politics of Pot", Time, November 4, 2002, page 57.

United States of America that there are no known medicinal uses for marijuana[7]. Consequently, marijuana has been classified as a drug as dangerous as heroin and LSD. This is clearly contrary to the truth. At this time, while Americans are dying overseas and at home in the service of protecting democracy, it is even more critical for the American people to have faith in the information being disseminated by government. Enclosed in this testimony are references to corroborating documents refuting the position of the Drug Enforcement Administration, the official watchdog of American Physicians and the medications they prescribe, and an agency under the guardianship of this committee. (A full copy of all of the references will be provided to Chairman Souder upon my arrival at the Hearing.)

AN ABBREVIATED HISTORY OF CANNABIS

"Marijuana" is a term used to describe the plants *Cannabis sativa* and *Cannabis indica.* Cannabis has been used as a medication for over five thousand years. "The first evidence of the medicinal use of cannabis is an herbal published during the reign of the Chinese Emperor Chen Nung five thousand years ago. It was recommended for malaria, constipation, rheumatic pains, 'absentmindedness,' and 'female disorders.'"[8] Marijuana was also recommended for "senile insomnia", analgesia, as a sleep inducer (hypnotic), in the treatment of gastric ulcers, morphine addiction, migraine headaches, tic douloureux, depression, and epilepsy.[9] "The first Western physician to take an interest in cannabis as a medicine was W. B. O'Shaughnessy, a young professor at the Medical College of Calcutta, who had observed its use in India."[10] Dr. O'Shaughnessy studied cannabis in India, then introduced the medication to European and American physicians. It was listed in the "United States Dispensatory" in 1854. By 1860, American doctors used cannabis to treat a multitude of medical problems "including tetanus, neuralgia, dysmenorrhea (painful menstruation), convulsions, the pain of rheumatism and childbirth, asthma, post-partum psychosis, gonorrhea, and chronic bronchitis. As a hypnotic (sleep-inducing drug) he compared it to opium"…"The whole effect of hemp being less violent, and producing a more natural sleep."[11]

Cannabis was readily dispensed by U.S. pharmacies until after passage of the Marihuana Tax Act of 1937, a strictly political shuffle motivated by Harry Anslinger under the Federal Bureau of Narcotics. Anslinger's campaign was orchestrated through an aggressive, but largely hysterical media campaign.[12] During Congressional hearings to decide the fate of cannabis as a medication, a spokesman from the American Medical Association, W. C. Woodward, M.D., J.D. noted, "It has surprised me, however, that the

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[7] US.GOV website, House of Representatives, Committee on Government Reform, Subcommittee on Criminal Justice, Drug Policy and Human Resources, News, "Chairman Souder wants you to know that Marijuana is not Medicine" plus related links.

[8] Grinspoon, Lester, M.D., Bakalar, James B., Marihuana, the Forbidden Medicine, Yale University Press, New Haven and London, 1997, page 3.

[9] Ibid., page 6.

[10] Ibid., page 4.

[11] Ibid., page 5.

[12] Ibid., pages 7-8.

facts on which these statements have been based have not been brought before this committee by competent primary evidence."[13] From the very beginning, the choice to ignore the medical therapeutics of cannabis was politically motivated, not based on truth.

In 1970, during a period of great upheaval in America, Congress passed the Comprehensive Drug Abuse Prevention and Control Act (also called the Controlled Substances Act), which placed cannabis in a category called "Schedule I." Schedule I drugs "have no known medicinal use" by definition.[14] Clearly, this was not scientifically based as evidenced by 5000 years of a longitudinal outcome-based folk medicine "study" (i.e. people from all over the world have been using cannabis for medicine after 5000 years of observation of how it works.) Nonetheless, cannabis became illegal with the passage of both these Acts, neither of which was based on scientific facts.

Subsequent to the Controlled Substances Act, several patients applied for special permission to use cannabis to relieve pain and suffering. As there was, indeed, evidence to support the use of cannabis as a medication, Federal drug agencies granted "Investigational New Drug" permits to patients to use marijuana medicinally. The Federal Government took over the dispensing,[15] of marijuana to several sick people and established a cannabis farm in Mississippi. Today there are seven Americans who continue to receive prescriptions of marijuana from the U.S. Government sent to them in the U.S. Mail.

In 1988, Francis L. Young, J.D., and Administrative Law Judge for the Drug Enforcement Administration reviewed the medical literature on Cannabis. "Based upon the foregoing facts and reasoning, the administrative law judge concludes that the provisions of the Act permit and require the transfer of marijuana from Schedule I to Schedule II. The Judge realizes that strong emotions are aroused on both sides of any discussion concerning the use of marijuana. Nonetheless it is essential for this Agency, and its Administrator, calmly and dispassionately to review the evidence of record, correctly apply the law, and act accordingly."[16] He *ordered* the DEA to change the classification of Cannabis such that patients could gain legal access through their physicians. The DEA disobeyed Judge Young and ignored his order. There were no enforcement measures available to force the DEA to comply.

The Compassionate Use Act of California ("Proposition 215") was passed in 1996. In it, patients who are "seriously ill Californians" are given the right to seek their physician's approval to use cannabis to aid in the treatment of their illnesses. Since passage of the act, much legislation has ensued. California lawmakers subsequently put into law a corollary to the Compassionate Use Act. Senate Bill 420 provides for systems to aid Law Enforcement in the compliance with California Law H&S Code Section 11362.5. Additional litigation resulted in a decision protecting patients and physicians from

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[13] Ibid., page 9.
[14] Op. cit.,
[15] "Medical Pot Users Win Key Ruling",
[16] United States Department of Justice Drug Enforcement Administration, Docket No. 86-22, September 6, 1988

interference in their relationships. The Supreme Court of the United States of America has upheld the right of autonomy in this matter for both patients[17] and physicians[18].

Although it is the Law, and although the Law has been supported by the Supreme Court, many enforcement measures have been meted out on both patients and physicians to try to prevent them from complying with California State Law. Many patients have lost their medicine and been subjected to criminal prosecution. William Eidelman, M.D. lost his license to practice medicine. Miriam ("Molly") Fry, M.D. lost her right to write prescriptions for antibiotics and everything else. The grandfather of the Medical Marijuana movement, Tod Mikuriya, M.D., was investigated at great length by the Medical Board of California and subsequently fined $75,000 for his care of medical marijuana patients.[19] Although no patient has complained to the Medical Board about my medical care, I am also under investigation for my care of three patients.

Many physicians who have medical marijuana patients in their practices are currently under investigation although the Medical Board of California's policy clearly states physicians are not to be unduly harassed: "The Board seeks to provide greater guidance to physicians to enable them to participate appropriately in the implementation of Proposition 215, while meeting their professional and ethical obligations under the relevant standard of care. Adherence to such guidance by both physicians and Medical Board enforcement staff will ensure that physicians are not investigated merely because they have issued recommendations for marijuana use to patients. Investigations must be based on information received by the Board which provides a reasonable basis to believe that the physician is not adhering to acceptable medical practice standards when making the recommendation."[20]

In fact, the Medical Board of California has not lived up to its own standards. Not only are the doctors being investigated, frequently without just cause, but physicians have benefited from no guidance from the Medical Board, whatsoever. Physicians evaluate whether a patient is ill and determine if the risk/ benefit ratio of using any medication warrants condoning the patient's use of the drug or not. Examining risk/ benefit ratios in the care of patients is exactly what physicians have been trained to do. It's our job.

Instead of trusting licensed physicians to make educated decisions regarding patient care, the Medical Board depends on its enforcement branch to attend to the physicians who care for medical marijuana patients. No physicians with the Medical Board of California have any experience or training in the management of this highly complex patient population. The care of Medical Marijuana patients is a specialty and requires much greater skills in many areas than does the traditional practice of medicine. The physicians of the California Cannabis Research Medical Group[21] have carved out

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[17] "Court Accepts Medical Pot Use", Los Angeles Times, July 19, 2002.
[18] "Medical Pot Use Given a Boost", Los Angeles Times, December 17, 2003.
[19] Ventura County Star, "Doctor could lose license over marijuana", July 14, 2003.
[20] Medical Board of California, Action Report, www.medbd.ca.gov, July, 2003.
[21] Gardner, Fred, O'Shaughnessy's, Journal of the California Cannabis Research Medical Group, "Cannabis Specialists Agree on Health History Questionnaire," Spring, 2004, page 2.

accepted Practice Guidelines, but they would greatly benefit from a cooperative relationship with the Medical Board rather than the current adversarial relationship. Doctors in the State of California are afraid to learn about how to use cannabis. In the eight years since passage of the Compassionate Use Act, only two educational programs for physicians have been presented.[22],[23]

Books have been written on the details of the history of cannabis. They are filled with facts, data, mystery, descriptions of maltreatment and calls for governmental reform. More and more literature is being published annually. Scientific studies documenting the safety and efficacy of "cannabinoids" (cannabis compounds) are being published (mostly in extra-American journals) with increasing frequency. The "medical marijuana movement" has evolved from a "grass roots" endeavor to become a progressively better organized demand for social reform. In the absence of a totalitarian government, the Medical Marijuana Movement will continue to flourish because its premise is exposing the misrepresentations about cannabis in the pursuit of compassion for sick people.

THE SCIENCE OF CANNABIS AS A MEDICATION

Even the government of the United States of America has documented the safety and efficacy of cannabis compounds in the treatment of chronic pain, neurological and movement disorders, nausea and vomiting, Glaucoma, appetite stimulation/ cachexia,[24] Wasting Syndrome, spasticity, Multiple Sclerosis, Tourette's Syndrome, Epilepsy, and Alzheimer's Disease.[25] A thorough review of the Institute of Medicine Report (a partial text is included in references) and the National Institutes of Health Report (included in references) clearly identify medicinal uses for marijuana sprinkled among the disclaimers about how it would be nice to do more research.

"Since oral delta-9 *THC has some analgesic activity*, it is highly likely that smoked marijuana has some analgesic activity in some kinds of clinical pain,"[26] is a direct quote from the NIH report. That's it. There is the science in review by a group of analysts who are clearly not part of the Medical Marijuana Movement. That statement alone warrants an order to the Drug Enforcement Administration to correct the mistake of labeling cannabis "without medical benefit". But, in fact, the entire report documents repeatedly that cannabis compounds in all formulations have medicinal benefit.

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[22] "Cannabis Therapy: Science, Medicine and the Law", University of California at San Francisco, San Francisco, CA, June 10, 2000.
[23] "Perspectives on the Clinical Application of *Cannabis Sativa* and *Cannabis Indica*", University of Southern California Keck School of Medicine, Los Angeles, CA, February 13, 2004.
[24] Ad Hoc Group of Experts, NIH.GOV, "Workshop on the Medical Utility of Marijuana. Report to the Director, National Institutes of Health", February 19-20, 1997, pages 1-30.
[25] Joy, Janet E., Watson, Stanley J., Jr. Benson, John A., Jr., Editors, Marijuana and Medicine Assessing the Science Base, Institute of Medicine, National Academy Press, Washington, D.C., 2003, http:books,nap.edu/catalog/6376.html, pages 137-191.
[26] Ibid., page 19 ("Analgesia: 2. What are the major unanswered scientific questions?")

"In conclusion, the available evidence from animal and human studies indicates that cannabinoids can have a substantial analgesic effect."[27] The IOM Report clearly refutes the position of the DEA in classifying Cannabis as a Schedule I drug. At the very worst, Cannabis should be included in the Schedule II classification (known medicinal uses with high abuse potential) along with cocaine and amphetamines.

In addition to the U.S. Government funded reports, a panoply of books have been written on the medical efficacy of cannabinoids. Of the many, I use Dr. Grinspoon's, Dr. Earleywine's and Dr. Russo's the most.[28,29,30]. (Dr. Earleywine has provided a copy of his book for the Committee.) Lynn Zimmer, Ph.D. and John P. Morgan, M.D.have published an excellent evaluation of the myths about marijuana.[31] Even the most cursory perusal of these texts reveals the great depth of science behind the use of cannabinoids in medicine.

Also available to review to discover the details about pharmacology, biochemistry, clinical uses and safety/ efficacy profiles of cannabinoids are *hundreds* of published scientific articles. I ran a literature search through the library at the University of Southern California Keck School of Medicine and printed hundreds of pages of recent studies documenting many therapeutic trials documenting the effectiveness of cannabis. I have attached a few as addenda to this testimony.

One article from the German literature, describes the "endogenous cannabis receptors" in the human body.[32] That is, human nerve cells and immune cells have pockets of tissue, like keyholes to a lock, whose sole responsibility is to bind to cannabis compounds. This discovery resulted in a search for an "endogenous" key-like compound produced by the body to plug in to those little locks. The discovery of the "endocannabinoid" (cannabis-like compounds produced in the body naturally), *Anandamide* has led researchers on a further quest to develop synthetic cannabinoids for use in medicine. There are over 483 natural compounds in the cannabis plant, with more than 66 "cannabinoids" (a distinctive class of compounds found only in the cannabis plant). Many cannabinoids function like delta-9 THC (tetrahydrocannabinol) to some degree. Many do not.

Perhaps the most important reason to value the use of cannabis as a medication is because of the testimonials from American citizens who have personally witnessed relief from suffering because of the ability to use cannabis as a medication.[33] We tend to undermine

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[27] Op. cit., Joy, Janet E., page 145.
[28] Op. cit., Grinspoon.
[29] Earleywine, Mitch, Ph.D., Understanding Marijuana A New Look at the Scientific Evidence, Oxford University Press, Oxford, New York, 2002, pages 1-317.
[30] Russo, Ethan, M.D., Grotenhermen, Franjo, M.D., Editors, Cannabis and Cannabinoids Pharmacology, Toxicology, and Therapeutic Potential, The Haworth Integrative Healing Press, New York, London, Oxford, 2002, pages 1-427.
[31] Zimmer, Lynn, Ph.D., Morgan, John P., M.D., Marijuana Myths Marijuana Facts, The Lindesmith Center, New York, San Francisco, 1997, pages 1-233.
[32] Pertwee, R. G., Forsch Komplementarmed, "Cannabis and Cannabinoids: Pharmacology and Rationale for Clinical Use", 1999;6 (suppl 3):12-15.
[33] CBS News, "Recipe for Trouble", CBSNEWS.com, March 7, 2002 12:21:49, pages 1-2.

these stories as "anecdotal", suggesting that a single patient's experiences are not that critical to care about. Many prefer to pretend these patients are merely lying, or manufacturing statements so that they can "get high." As a physician with twenty-three years experience caring for the sick and suffering, I find this attitude disrespectful and un-Christian (I beg forgiveness from those who are offended by my religious orientation.) If there is just one person who is truly benefited from the use of cannabis, it should not be denied to them. It is clearly inhumane and a violation of that poor soul's "right to life, liberty and the pursuit of happiness" to be forbidden access to *any medication* that can relieve his/her torment.

CANNABIS AND ATTENTION DEFICIT DISORDER (ADD)

Attention Deficit Disorder is a neuropsychiatric disorder which affects 3-7% of American children and 3-4% of adults.[34] ADD has three subtypes: Inattentive, Hyperactive and Combined. Patients with ADD or its partner ADHD (Attention Deficit Hyperactivity Disorder) have difficulty with the executive management of their ability to attend to tasks. They frequently and inappropriately have difficulty focusing, listening attentively, completing homework and projects, organizing tasks and activities. Many are forgetful ("absentminded" in archaic terminology), impatient, fidgety, overly active, talkative, intrusional and have difficulty in engaging in quiet play.

There are multiple variations on the syndrome, but approximately 70% of people who suffer from ADD also experience other neuropsychiatric problems, including mood disorders (15-75%) especially depression, antisocial disorders (23-64%) including oppositional-defiant behavior disorder, anxiety (8-30%), and learning disabilities (6-92%.)[35] ADD/ ADHD can be an extremely debilitating problem and generates untold cost to society. Studies suggest incarcerated criminals have a disproportionate incidence of ADD/ ADHD, up to 40% in some studies.[36]

From my experience, it is the adolescents who seem to be having the greatest difficulty in coping with ADD. A teenager with difficulty focusing, listening attentively, completing homework and projects, organizing tasks and activities who is also forgetful ("absentminded"), impatient, fidgety, overly active, talkative, intrusional and has difficulty in engaging in quiet play is likely to have social and academic problems. This is particularly true if the adolescent also experienced life events resulting in him/ her having a poor self image. Adolescents with mood disorders (15-75%) especially depression, antisocial disorders (23-64%) including oppositional-defiant behavior

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[34] Brown, Thomas E., Ph.D., "Recognizing ADHD: Neurobiology, Symptoms, and Treatment, New Approaches to ADHD: Addressing Patient Needs From a Whole-life Perspective, Pragmaton Office of Medical Education supported by an unrestricted education grant from Eli Lilly and Company, 2001, page 3.

[35] Spencer, Thomas J., M.D., "ADHD in Children and Adults: Diagnosis and Comorbidity Issues", New Approaches to ADHD: Addressing Patient Needs From a Whole-life Perspective, Pragmaton Office of Medical Education supported by an unrestricted education grant from Eli Lilly and Company, 2001, page 13.

[36] McCallon, M.D., T. Dwaine, "If He Outgrew It, What Is He Doing in My Prison?", http://add.org/images2/prison.htm, March 25, 2004, pages 1-3.

disorder, anxiety (8-30%), and learning disabilities (6-92%.)[37] can be dangerous. ADD/ ADHD can be an extremely debilitating problem and generates untold cost to society.

Patients with ADD/ ADHD frequently need medication to be able to function normally in society. Unfortunately, amphetamines are the most commonly used drugs to treat ADD in the United States today. Amphetamines can have very undesirable side effects. They can contribute to increased seizure activity, mental illness, cachexia and malnutrition, insomnia and severe behavior disorders. Only 70% of children with ADD respond well to amphetamines, anyway. The use of amphetamines in already emotionally impaired and academically challenged adolescents is not the best idea. Yet, Americans spend more than a billion of dollars every year buying legal amphetamines for their children who have ADD.

The more amphetamines we sell in the U.S., the more amphetamines we need to manufacture. The more amphetamines we manufacture, the more amphetamines can leak into the black market. Amphetamines in the black market fund crime. And they are addictive. Amphetamine users crave more and more drug. Amphetamine abuse is a serious problem in America, and we should limit amphetamine manufacture and distribution, *especially* for use in children and adolescents.

The other legal drugs used to treat ADD are helpful in many patients, but they all have side effects in some people. Actually, the other five of the nine drugs used to treat ADD in this country haven't even been scientifically tested to find out if they are effective treatments for ADD in children.[38,39] These are drugs for depression and high blood pressure, and they all have bad side effects in some people. Yet, doctors all over America write prescriptions for depression and high blood pressure medications to treat ADD in children. Even though those drugs have not been tested scientifically, if they do help the child, it is not uncommon to use a drug "off label"[40] I support the physician's right to be able to try them.

Although not all adolescents with ADD become violent while taking amphetamines, enough are emotionally impaired to warrant having a medication available, like cannabis, whose specific side effect is to make adolescents more peaceful. We really don't need another Columbine. With the help of knowledgeable physicians, adolescents who are suffering with ADD can have access to a medication that can help them function more normally in society while at the same time helping them to be more tranquil rather than more agitated, sleepless, irritable and anorexic. Because all medicines used to treat ADD have side effects, even cannabis, it is better to use any medication only if it is truly necessary; and only under the guidance of an *experienced* physician. Of all the drugs used to treat ADD, cannabis has the least number of serious side effects.[41],[38]

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[37] Op. cit., Spencer, Thomas J., M.D., page 13.
[38] Op. cit., Brown, Thomas E., page 14.
[39] Thomson's Physician's Desk Reference, Fifty-eighth Editions, 2004, multiple pages.
[40] Thomson's Physician's Desk Reference, Fifty-eighth Editions, 2004, Page 3295 under "General Information."
[41] Physician's Desk Reference for Herbal Medicines, First Edition, Medical Economics Company, New Jersey, 1998, pages 712-714.

There are hundreds of case reports of patients who report improvement of their ADHD with Cannabis.[42] There is evidence in the laboratory to show cannabinoids are effective in treating rats with ADHD.[43] We need more research to define which routes of administration (oral seems preferable clinically), dosing, strain types to use, etc. Unfortunately, no pharmaceutical companies are motivated to spend the money on research and the United States Government has a monopoly on the available (poor quality) marijuana and research permits.

THE PROBLEM DEFINED

The problem of using Cannabis as a medication is not an issue of morality. It is immoral to deprive sick people of any medication that can help them.[44]

The real problem with allowing patients to use Cannabis as a medication is *economic*s.

If Cannabis were approved for use in just the ADD/ ADHD market alone, it could significantly impact the $1 Billion a year sales[45] for traditional ADD/ ADHD pharmaceuticals. Why would anyone want to give their child an expensive pill (averages about $100 a month)[46] with unacceptable side effects if s/he could just go into the backyard, pick a few leaves off a plant and make a tea for him/ her instead? Multiply those numbers by the tens of medical diagnoses that are effectively treated by Cannabis (for example chronic pain, which is a much bigger business than the treatment of ADD; or Glaucoma, or Multiple Sclerosis, etc) and it is easy to see the pharmaceutical industry would suffer beyond calculation.

We currently have the most expensive pharmaceuticals in the world, largely because American citizens are funding the research and development of new drugs. What company would want to invest the money in R & D if the expected revenues could be diminished by a plant able to be grown in the backyard? It's a serious and real problem. Of course, some companies would adapt. For example, Eli Lilly Pharmaceuticals manufactured a Tincture of Cannabis in the 1920's.[47] Perhaps Lilly would be wise to begin R & D in Cannabinoids to try to beat the foreign markets (e.g. GW Pharmaceuticals in Great Britain.) Perhaps Lilly's $575 million profit in the fourth

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[38] See 38 above.
[42] Gardner, Fred, "Which Conditions are Californians Actually Treating With Cannabis?", O'Shaughnessy's, Journal of the California Cannabis Research Medical Group, Summer, 2003.
[43] Adriani, Walter, et.al., "The spontaneously hypertensive-rat as an animal model of ADHD: evidence for impulsive and non-impulsive subpopulations," Neuroscience and Biobehavioral Reviews, 27 (2003(pages 639-651
[44] Clark, Peter A., "The Ethics of Medical Marijuana: Government Restrictions vs. Medical Necessity", Journal of Public Health Policy, (2001?), Volume 21, Number 1, pages 40-60.
[45] Attention Deficit Disorder Help Center, "Drug Concerta, Atomoxetine, Metadate CD, Ritalin LA, Focalin; The New Meds.", http://www.add-adhd-help-center.com/newsletters/newsletter_31dec02.htm.
[46] Jensen, Claudia, M.D., Telephone survey of local pharmacies, 2004.
[47] See photograph of Tincture of Cannabis and letter from Parke-Davis dated June 19, 1968.

quarter, 2001[48] and other annual profits could be invested in less risky business (although pharmaceuticals don't appear to be too risky at this time. If Cannabis stays off the market, pharmaceuticals are more secure.)

Two other American traditions would suffer if Cannabis were reclassified as (at worst) a Schedule II drug. It is highly likely Americans who could use Cannabis more would use alcohol and tobacco less. Most Cannabis users I have interviewed are not daily alcohol or tobacco consumers; and this seems to be a consensus among the Physicians who actually manage Medical Marijuana patients. Rarely do patients use other illicit drugs, although most of them have a history of having tried other drugs in their lifetimes.

But the real economic catastrophe to be expected if Cannabis is reclassified would be to the Law Enforcement and Judicial branches of government. "According to ONDCP, the $18.822 Billion spent by the federal government on the drug war in 2002 breaks down as follows:…"

"…Domestic Law Enforcement: $9.513 Billion (50.5% of total)
Interdiction: $2.074 Billion (11.0% of total)
International: $1.098 Billion (5.8% of total)
In other words, $12.686 Billion in 2002 was directed to supply reduction, i.e. law enforcement (67.4% of total.)"[49]

"Nearly eight cents of every dollar spent by State and local governments in 1999 was for justice activities."[50] And, as long as Cannabis is classified Schedule I, the Federal Government will be forced to continue to spend money on investigating, arresting, prosecuting, incarcerating, and "rehabilitating" medical marijuana users. The marijuana smokers of America (some 4.2% of the population, and the numbers actually rose since the "War on Drugs" has begun) will continue to funnel $10.6 billion annually into the black market to buy marijuana.[51] That is, *10.6 Billion Dollars* are spent funding criminals selling marijuana in this country, and the American people are paying it.

CONCLUSION: What Should We Do?

Tell the truth. Cannabis does not fit into the category "no known medicinal use."

Enforcement procedures should be implemented to carry out Judge Young's 1988 orders to the Drug Enforcement Administration. Marijuana should actually be rescheduled as

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[48] "Prozac's slippage cuts Lilly's earnings", The Indianapolis Star, January 25, 2002, http://www.indystar.com/library/factfiles/business/companies/lilly/stories/2002_0125.html, page 1.
[49] Office of National Drug Control Policy, "National Drug Control Strategy: FY 2003 Budget Summary" (Washington, DC: Office of the President, February 2002), Table 2, page 6 as reported by Drug War Facts at http://www.drugwarfacts.org/marijuan.htm.
[50] Gifford, Sidra Lea, US Department of Justice, Bureau of Justice Statistics, Justice Expenditure and Employment in the United States, 1999 (Washington, DC: US Department of Justice, February, 2002), page 4 as reported by Drug War Facts at http://www.drugwarfacts.org/marijuan.htm.
[51] "Changing the Way Americans Think About Marijuana Talking Points", http://reform.house.gov/CJDPHR/News/DocumentSingle.aspx?DocumentID=1692 plus attachments.

Schedule III because of its safety profile, but Schedule II would be more honest than what it is now.

Research grants should be awarded to investigators with the intention of producing studies to define how to use cannabis effectively.

Systems should be developed to divert the $10.6 billion Americans spend on marijuana annually into Public Health, Law Enforcement (to guard the crops and distribution), American farmers (to grow the medicine), to Pharmaceutical Industries to promote research and development on smoke-less delivery forms, and to the tobacco giants to manage the smoked products. The American farmers employed should preferably have previous experience in the cultivation and processing of Cannabis as the "medicine" being produced at the Mississippi farm reportedly is embarrassingly low quality. All of the funds could be administered through a "Tax Stamp" system which could feasibly generate $0.50 per gram of Cannabis sold.

We as a nation should value the truth about marijuana. It is the only compassionate thing to do. When law enforcement is freed from mercilessly targeting sick people, it can focus on hard drugs, like methamphetamine and cocaine.

The truth is: Americans should never have to be afraid of the law if they need a medication to relieve pain and suffering.

Thank God in California the law protects patients from being punished for using a medication that helps them. Thank God that the Supreme Court Justices of the United States of America have their eyes open to the truth. I pray that the Committee on Government Reform will take action. Please ask them to do so.